

CASH ASSISTANCE PROGRAM FOR IMMIGRANTS (CAPI) NOTIFICATION OF INTER-COUNTY TRANSFER

To: (Receiving County/Consortium)	Date:
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Transferring County/Consortium and Address:	Case Name:	
	SSN:	Sending Case No.:
	Spouse Name:	
Date Moved/Date Notified:	SSN:	Sending Case No.:
CAPI Discontinuance Date:	Participant's New Residence Address:	
Prior Living Arrangement: Independent <input type="checkbox"/> Shared <input type="checkbox"/> Living with Adult Child <input type="checkbox"/> Other <input type="checkbox"/>	Participant's Mailing Address (if different)	
Current Living Arrangement (after move), if known: Independent <input type="checkbox"/> Shared <input type="checkbox"/> Living with Adult Child <input type="checkbox"/> Other <input type="checkbox"/>	Participant's Phone Number: Contact Person (if Different) Relationship to Participant: Phone:	

DOCUMENTATION SENT		OVERPAYMENT INFORMATION	
<input type="checkbox"/> SAWS 1	<input type="checkbox"/> DAPD Verification	Balance Owed	Adjustment
<input type="checkbox"/> IAR (SOC 451)	<input type="checkbox"/> Copy of whole file	\$	\$
<input type="checkbox"/> Latest Statement of Facts	<input type="checkbox"/> Sponsorship Verification		
<input type="checkbox"/> Redetermination Form	<input type="checkbox"/> Noncitizen status verification		
<input type="checkbox"/> State IAR (SOC 455)	<input type="checkbox"/> Other		

OTHER INCOME			
Name	Source		Amount
			\$
			\$
Transferring Worker Name	Worker #	Phone Number	Fax Number
Receiving Worker Name	Worker #	Phone Number	Fax Number

☐ Transfer Accepted

☐ Transfer Rejected: Reason: _____
